



ACTIVE FEE-FOR-SERVICE BENEFIT SUMMARY

The following comparison is **only a summary** of the major features of the Plan.
Not all exclusions and limitations have been included.

Important! You must pre-certify your hospital confinements.

If you do no pre-certify your hospital stay, the hospital benefits that would usually be payable will be reduced by 10%.

**BENEFITS
EFFECTIVE
JUNE 1, 2011**

COMPREHENSIVE MAJOR MEDICAL BENEFITS

Calendar Year Maximum Benefit: \$5,000,000 per person

Out of Pocket Maximum:

If you use a Contracting Provider, your out-of-pocket maximum expense will be \$2,000 per person or \$4,000 per family, per calendar year. If you use a Non-Contracting Provider, your out-of-pocket maximum expense will be \$3,000 per person or \$9,000 per family, per calendar year. When your applicable co-payment limit is reached, benefits will be paid at 100% for the balance of the calendar year (50% for extended care facility).

ACTIVE PARTICIPANTS & DEPENDENTS

Fee-For-Service Plan (Benefits paid by the Plan)	Contracting Provider	Non-Contracting Provider
Calendar Year Deductible	\$250 / \$500; NEVER WAIVED WHEN APPLICABLE	\$500 per person, \$1,500 per family; NEVER WAIVED WHEN APPLICABLE
Preventative Physical Care, Well Baby and Routine Female Care	100% of contract rate; no co-payment or deductible	60% of covered charges; Deductible Applies
Non-Preventative Office Visit	100% of contract rate after a \$20 co-payment Deductible Does Not Apply	60% of covered charges; Deductible Applies
Emergency Room	90% of contract rate; Deductible Applies	90% of covered charges; Deductible Applies
Inpatient Hospital	90% of contract rate; Deductible Applies	60% of covered charges; Deductible Applies
Outpatient Surgery	90% of contract rate; Deductible Applies Certain Surgeries May Require Pre-Authorization	60% of covered charges; Deductible Applies Certain Surgeries May Require Pre-Authorization
Chiropractor & Acupuncture	100% of contract rate after a \$20 co-payment; up to a maximum benefit of \$2,000 per calendar year	60% of covered charges to a maximum payment of \$2,000 per calendar year; Deductible Applies
Outpatient Therapy (Physical, Respiratory, Speech and Occupational)	100% of contract rate after a \$20 co-payment; deductible does not apply; Maximum benefit of 20 visits per calendar year	60% of covered charges to a maximum benefit of 20 visits per calendar year (<i>combined w/ Contracting Provider Benefits</i>)
Infertility	Not covered	Not covered
Vasectomy, Tubal Ligation, Elective Abortions	80% of contract rate; Deductible Applies Outpatient Surgery	60% of covered charges; Deductible Applies Outpatient Surgery
Emergency Ground Ambulance	No contract provider (See non-contracting benefit)	\$50 co-payment per ground transport Deductible Does Not Apply
Home Health Care, Medical Supplies, Orthopedic Braces, Prosthetic Appliances	90% of contract rate after a \$20 co-payment Deductible Applies	60% of covered charges Deductible Applies
Lab and X-Ray	100% after a \$20 co-payment	60% of covered charges
Extended Care Facility	45% of covered charges; 55 days per period of disability; minimum 5-day inpatient hospital stay required prior to admission; must be readmitted within 7 days of discharge	35% of covered charges; 55 days per period of disability; minimum 5-day inpatient hospital stay required prior to admission; must be readmitted within 7 days of discharge
Behavioral / Mental Health	Pre-authorization required by MHN (800) 977-7962 Member and Eligible Dependent Benefit	No Benefit Available Out of Network
Inpatient Treatment	90% up to a maximum benefit of 30-days per calendar year; Deductible Applies; 60-day lifetime max benefit	
Outpatient Treatment	\$30 (individual) \$15 (group) Maximum 30 visits per calendar year Deductible Does Not Apply	
Chemical Dependency	Pre-authorization required by MHN (800) 977-7962 / Member Benefit Only	No Benefit Available Out of Network

ACTIVE PARTICIPANTS & DEPENDENTS (continued)

Fee-For-Service Plan (Benefits paid by the Plan)	Contracting Provider	Non-Contracting Provider
Outpatient	100% after a \$20 co-payment; coverage limited to two episodes per lifetime	
Inpatient	90% up to a maximum benefit of 30 days per calendar year limited to two episodes per lifetime; Deductible	
Detoxification	90% limited to four episodes per lifetime; Deductible Applies	
*Prescription Drug Benefit EnvisionRxOptions (800) 361-4542		All prescriptions must be provided through an EnvisionRxOptions Retail Pharmacy or Orchard Pharmaceuticals Mail Order Service to be covered.
Retail Network Walk-in	30-day supply	
Generic	\$10 co-payment	
Formulary Brand Name	\$20 co-payment	
Non-Formulary Brand Name	\$40 co-payment	
Mail Order	90-day supply	
Generic	\$20 co-payment	
Formulary Brand Name	\$40 co-payment	
Non-Formulary Brand Name	\$80 co-payment	
Supplemental Accident Benefit	80% of contract rate; Deductible Does Not Apply	100% of covered charges incurred within 90 days of an accident up to a maximum payment of \$300 for medical and \$100 X-ray and lab services per accident Deductible Does Not Apply
Hearing Care (Exams)	100% of contract rate; no co-payment or deductible Benefit limited to one exam per calendar year	100% of covered charges; benefit limited to one exam per calendar year; Deductible Does Not Apply
Hearing Aid Benefit	90% of covered charges up to a maximum payment of \$2,000 per device; 1 device per ear (once every 3 years to the date); Deductible Does Not Apply	90% of covered charges up to a maximum payment of \$2,000 per device; 1 device per ear (once every 3 years to the date); Deductible Does Not Apply
Vision Benefit <i>Vision Service Plan</i> (800) 877-7195	\$25 deductible per 12 months; Vision exam once per 12 months; Lenses: once each 12 months; 2 nd pair glasses: for member only, \$25 deductible per 12 months	Not Covered (must use VSP or Spectera Vision Provider)
Frames	\$150 frame allowance plus lens extras; once every 12 months for member and dependents	
Contact Lenses	\$150 allowance	
<i>Spectera Vision</i> (800) 839-3242	\$10 exam and \$10 materials co-payment; Vision exam once per 12 months; Lenses: once each 12 months; 2 nd pair glasses: for member only, \$10 deductible per 12 months	
Frames	\$50 frame allowance; once every 24 months for members and dependents	
Contact Lenses	\$105 allowance	
FFS Dental Benefits Delta Dental PPO (800) 765-6003	Contact Delta Dental for Fee Schedule Information	Contact Delta Dental for Fee Schedule Information

FOR ADDITIONAL BENEFIT INFORMATION PLEASE CONTACT THE TRUST FUND OFFICE AT (800) 527-4613